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HEALTH CARE IN THE UNITED STATES AND CANADA

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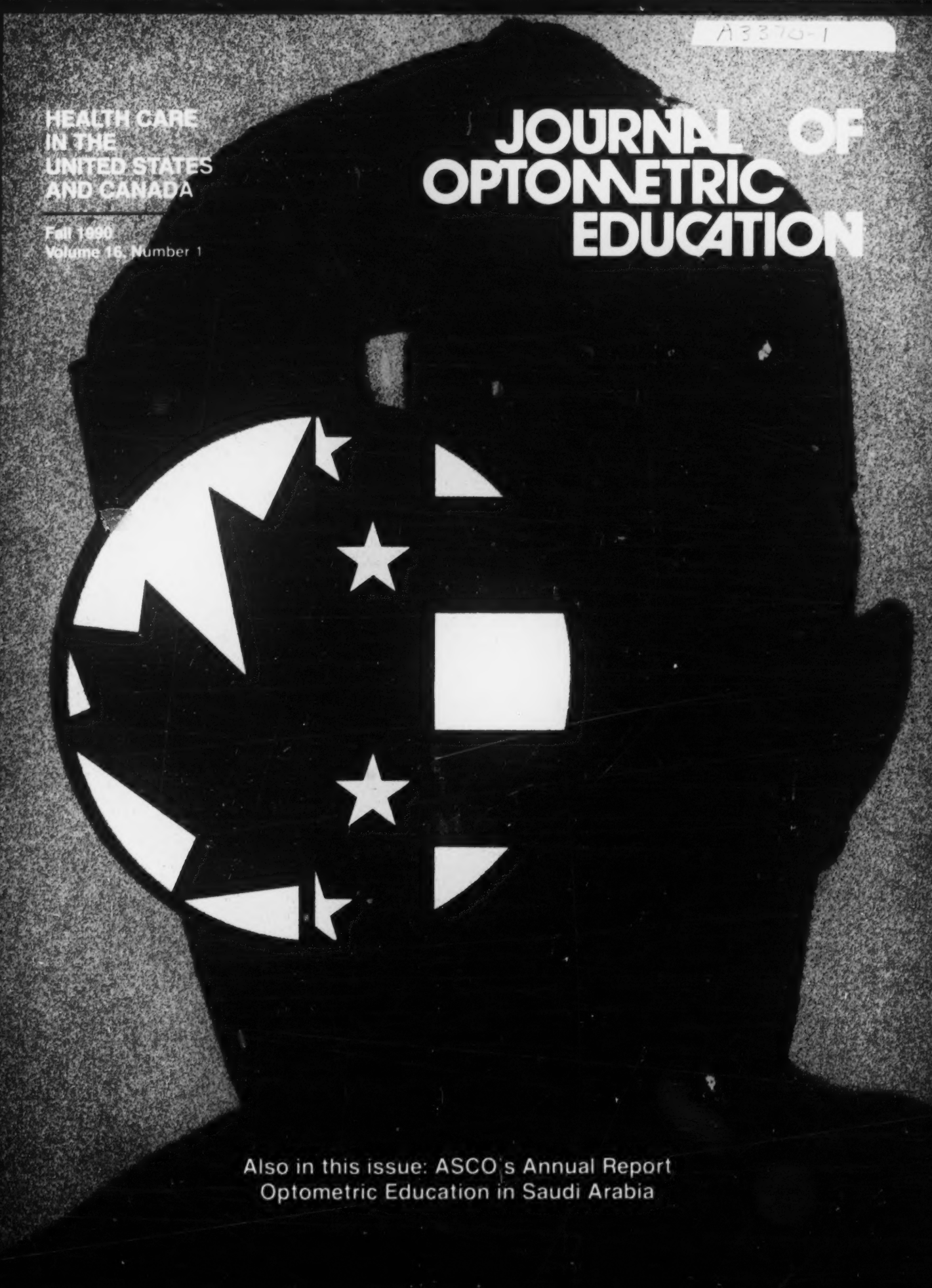

Also in this issue: ASCO's Annual Report
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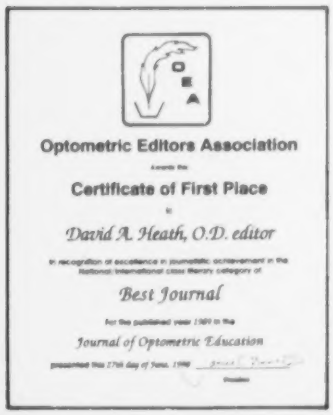

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Some Comparisons Between Health Care in The United States and Canada

William M. Lyle, O.D., Ph.D.
Barbara E. Robinson, O.D., M.P.H.

Introduction

America's health care economy has been called "a paradox of excess and deprivation."[1] The Health Care Financing Administration (HCFA) has projected that in the United States health care spending, according to present trends, will reach 15 percent of the gross national product (GNP) by the year 2000.[2] It is estimated that 35 to 37 million Americans have no medical care insurance, public or private.[1,3] Some have suggested that a solution to these problems might lie in adopting a universal health insurance system.

Colleagues in the United States often ask about Canada's health plan. Their concerns seem to stem from a general fear of what some call socialized health care. They enquire about such matters as:

- lack of incentive to do good work; equal pay to the best and the worst doctor; lack of freedom of choice; becoming a salaried practitioner. (None of these problems have materialized.)
- increased taxes, government control.
- imposition of quality control; peer assessment of quality of services, need to justify fees.

Canada has had a universal health insurance system in place since 1968. Before implementing this system Canada's health care spending as a percentage of national income was similar to and at times slightly higher than that of the United States (6% of GNP in Canada compared to 5.5% of GNP in the United States in 1961).[4] Before 1960 the costs of health care in Canada were met by a mixture of personal, fee-for-service, private sector insurance plans and limited government support. The Canadian approach to the development of a universal health insurance system has been to provide, step by step, major segments of publicly-financed personal health care to the whole population. The programs are designed to ensure that all residents of Canada have access to prepaid health and hospital care when needed. The completion of universal public coverage in 1971 has had a stabilizing effect on Canada's health care expenditures. Currently Canada's total health care expenditures are 8.6% of the GNP and the United States spends about 11.5%. (Table 1.)

In the United States there is concern that the present health care system is too expensive while in Canada some have accused the government of paying too little. What effect has approximately twenty years of universal health insurance had on Canada's health care sys-

TABLE 1
Health care costs as a proportion of GNP[1,4-10]

	U.S.A.	Canada	U.K.	Japan
1970	7.6%	7.2%		
1971	7.6%	7.4%		
1980	9.5%	7.4%	5.8%	6.4%
1981	9.2%	7.7%		
1982	10.2%	8.6%		6.7%
1983	10.5%	8.6%	6.2%	
1984	10.7%	8.4%		
1985	10.7%	8.6%		
1986	11.1%	8.5%	6.2%	6.7%
1987	11.0%	8.6%		
1990*	11.5%			
1995*	12.2%			

*Estimated

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This paper is based on a talk presented at the 19th Congress of the American Optometric Student Association, Toronto, Ontario, Canada, January 1989.

tem? A comparison of health care in the United States and Canada might offer some insights into the advantages and disadvantages of each system.

Before comparing health care in the two countries we looked at problems common to both countries in the provision of health care.

Problems in Providing Health Care

Financial

Between 1960 and 1984 annual health care costs have increased almost 100 percent in the United States and about 50 percent in Canada. Relman refers to the present era of cost containment as the revolt of the payers.[7,11] Provincial governments allocate about 30 percent of their total revenue for health care. (Table 2). In Canada, health professionals estimate the fees they believe to be appropriate for their work, then negotiate with the provincial government for the actual fee they will receive. Generally, physicians in Canada have obtained over 75 percent of the fee they requested. The actual subdivision of the money to the various subspecialties of medicine is decided upon by the physicians themselves.[6] Physicians' incomes are generally larger than those of dentists, lawyers, accountants, engineers, architects[6] and optometrists. In Ontario a physician's income is about 5 times the average wage of an industrial worker; in the United States a physician's income is about 5.5 times the average wage of an industrial worker.[6] Physicians' income is increasing at the rate of 8.8 percent a year in Canada and 15 percent a year in the United States; i.e., about twice the rate of inflation.[12] Approximately half the increased income of Canadian physicians is obtained by seeing more patients each working day or by more creative billing.[16] (Presumably creative billing means arranging the bill to include costs of the more expensive services.)

A working man in Ontario pays about $820 a year for comprehensive health insurance for himself and his wife; the insurance covers doctors, hospital, prescribed drugs, etc.[6] No premiums are required in some provinces (e.g. Manitoba, New Brunswick, Saskatchewan, British Columbia), as all costs are paid through taxes. No premiums are paid in any province by those who have reached 65 years of age or by those without income, e.g., children, students, unemployed, and those unable to work.

Cost of administering health care programs is 2.5 percent of total health spending in Canada and about 8.5 percent in the United States.[6,16] (Table 3).

TABLE 2(a)
Average annual payment from Ontario Health Insurance Plan to full time practitioners

	Physician	Optometrist
1986-1987	$170,509	$75,000
1987-1988	$197,000	$75,700*
1988-1989	$238,000*	

*Estimated

If the patient requires new spectacles, contact lenses or orthoptics the patient also pays a treatment fee to the optometrist (as well as paying the laboratory bill for materials) since treatment services and ophthalmic appliances are not covered by the Plan.

The 1987-1988 Annual Report of the Ontario Ministry of Health (page 19) shows the following claims paid:

TABLE 2(b)

	Claims paid to practitioners	Percent of total
Physicians	$3,355,870,827	92.5
Optometrists	62,828,804	1.7

If the resource-based relative value scale of payments to ophthalmologists is adopted, ophthalmologists in the United States will receive a reduction of 23 to 40% in their income.[12,13] The average ophthalmologist makes more money from office based services than from surgery.[13] For ophthalmologists in the United States the average major surgical case load is less than 100 each per year.[14] In Australia and in the United States ophthalmologists perform about 40% of the refractions. In the United States surgeons receive from six to seven times more money than primary care physicians.[15]

TABLE 3
Distribution of certain health care costs as a proportion of GNP,[16] (1985)

Percentage of GNP spent on	U.S.A.	Canada
Insurance, overhead costs, costs of prepayment and administration	0.59%	0.11%
Payments to hospitals	4.16%	3.48%
Payments to physicians	2.07%	1.35%

TABLE 4
Numbers of physicians and optometrists (approx.)[6,21-24]

	U.S.A. 1985		Canada 1985	
Number of active civilian physicians		500,000		51,996*
Population ratio	208 / 100,000	= 1 / 481	204 / 100,000	= 1 / 491
Medical school enrollment		66,600		7,350
Number of medical schools		127		16
Percentage of female students**		33%		43%
Number of new MD graduates each year		16,650		1,835
Number of active optometrists		25,000		2,386
Population ratio	10.6 / 100,000	= 1 / 9434	9.4 / 100,000	= 1 / 10,688
Optometry school enrollment		4,500		400
Number of optometry schools		17		2
Percentage of female students		30%		50%
Number of new ODs each year (plus a few foreign schools)		1,100		100

*Includes residents and interns.
**A female physician provides about 70% of the total person-years of service that a male physician provides.[6]

Ratio optometrists/ophthalmologist. (All values approximate.) U.S.A. 2/1, Canada 3/1, U.K. 10/1 and Australia 2.3/1. The American Bureau of Health Manpower recommends 5/1 for 1990.[14]

TABLE 5
Suggested ideal ratios of practitioners[6,23,24]

	U.S.A. (1986)	Canada (1986)
Population	240,656,000	25,625,200
If ideal ratio is 1/500 physicians	need 481,700 have 493,700 surplus 12,000 = 2.5%	need 51,000 have 51,996 surplus 996 = 1.9%
If ideal ratio is 1/40,000 ophthalmologists (Some advise 1/54,000)	need 60,200 have 66,200 surplus 6,000 = 10%	need 650 have 900 surplus 250 = 38%
If ideal ratio is 1/10,000 optometrists	need 24,065 have 25,000 surplus 915 = 3.8%	need 2560 have 2386 deficiency 174 = 6.8%

All governments are striving to put a limit on health care costs.[10] These efforts are made more difficult by the rapid increase in the number of health care practitioners, the aging of the population, the development of new expensive technology and higher expectations of the public. Managed health care has become necessary everywhere. Rationing of health care will become an ethical issue.[9,10,17] Potentially an insurance company or other third-party payer will be able to influence the care that a patient will receive.

Aging of the population

Certain demographic changes are well-known. People are living longer, and the proportion of those 65 years of age or older is increasing rapidly in most countries.[18] By the year 2000 nearly 1/5 of the population will be over 65 years of age in the United States and Canada. Practitioners feel that care of the elderly is less satisfying. The elderly require more physician time, hospital beds, drugs, nursing homes, glasses, hearing aids and low vision aids. More health care workers are needed to care for the elderly.[9] All these factors are driving up health costs.[10]

Excess numbers of practitioners

In both the United States and Canada there are too many physicians.[6,7,9] The era of medical school expansion began in the late 1940s. An excess of physicians has been shown to result in excess surgery, e.g., tonsillectomy, breast removal, cataract surgery,[14,19] hysterectomy, cesarean sections[20] and coronary by-pass operations. There is no evidence that a physician/patient ratio greater than 1/600 improves health care. Physicians increase their volume of services when payment rates are cut thus preventing price controls from limiting the overall costs of physicians' services.[12] The increasing number of physicians (and their increased personal income) drives up total health costs.[16] Equating the level of health with the availability of physicians and hospitals is inadequate.[21] Medical schools, dental schools, and residency positions are now being cut back.[17] (Tables 4,5) Even

TABLE 6
Trends in Infant Mortality Rates (per 1000 live births)[6,12]

Country	Year												
	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987[10]
United States	16.1			13.8	13.1	12.6	11.9	11.5	10.9	10.6	10.5	10.4	
United Kingdom (England & Wales)	15.7	14.3	13.8	13.2	12.8	12.0	11.1	10.8	10.1	9.5	9.4		
Canada	14.3	13.5	12.4	12.0	10.9	10.4	9.6	9.1	8.5		8.0	7.9	
Japan	10.0	9.3	8.9	8.4	7.9	7.5	7.1	6.6	6.2	6.0	5.5		5.2

Additional sources:
1986 Demographic Yearbook, Thirty-eighth issue, United Nations, New York, 1988.
1985 Demographic Yearbook, Thirty-seventh issue, United Nations, New York, 1987.
1984 Demographic Yearbook, Thirty-sixth issue, United Nations, New York, 1986.
1983 Demographic Yearbook, Thirty-fifth issue, United Nations, New York, 1985.
1980 Demographic Yearbook, Thirty-second issue, United Nations, New York, 1982.

TABLE 7
Neonatal mortality rate (deaths under 28 days of age per 1,000 live births)[9]

	U.S.A.	Canada
1971	15.1	12.4
1981	8.5	6.4
1982		5.9
1983		5.5
1984		
1985		5.2
1986		5.1

though enrollment is now declining it is estimated that by the year 1990 there will be 70,000 physicians in excess of the need in the U.S.A. and by the year 2000 the excess will be 145,000.[13] This includes a surplus of 4,700 ophthalmologists. A similar excess exists in some parts of Canada. More and more physicians in the United States are on salary, especially the younger ones (40 to 60 percent).[13]

The ideal case load for an optometrist is probably 2400 patients a year or not many more than ten a day, with allowance for holidays and attending continuing education courses. Comparable daily patient loads for physicians vary widely depending on specialty, but many book patients for a 15-minute office call. Ophthalmologists estimate that they can see about 5000 patients a year or more than 20 a day.

Influence of for-profit organizations

Ten to fifteen years ago, for-profit companies began to expand in the health field.[18,25] They hoped to achieve economies of scale, more efficient management, better control of planning, closer control of nurses and support staff and thus to make a profit. The government in the United States encouraged the for-profit companies because they hoped:

- to shift the cost burden off the government.[6]
- to reduce the pressure for a national health plan.[18]
- to take advantage of the excess of physicians and thus squeeze down costs in a market-driven economy.[3,6,7,17,18]
- to pressure physicians to leave metropolitan areas and practice in smaller communities.[6,22]

For-profit projects experienced the following problems.[25]

- businessmen lacked the skills to run a hospital. They hired excess administrative staff.
- they were unable to attract the best practitioners.
- their walk-in clinics antagonized the local practitioners. (Cost to a patient who visits a typical walk-in clinic averages $65.00 for about 15 min of a physician's time.)
- they tried selling health insurance but were not successful at it.
- some set up Health Maintenance Organizations (HMO's) or Preferred Provider Organizations (PPO's) but this proved to be complicated.
- the profit goes to the shareholder not to the practitioner.
- physicians working in for-profit centers complained that if the center worked on a per capita basis[26] or on a fee-for-service basis,[27] pressure was put on the physician to maximize income for the company. Clinical decisions tended to be altered by financial considerations.[8] Professional ethics are modified by commercial exigencies. Decisions about health care are influenced by the profit motive.

The results indicate that market forces do not work well in health care.[16] Entrepreneurship creates a two-tiered health care system,[18,28] a bottom-line attitude to health care.[27] Market forces do not lead to an efficient or fair outcome.[1] As Flexner said in 1910, "Medicine, curative and preventive, has

indeed no analogy with business . . . the medical profession is supported for a benign, not a selfish, for a protective, not an exploiting, purpose."[29] For-profit companies have, however, been successful owners and managers of chronic care facilities such as nursing homes.

Presence of underserviced groups

In all countries there are underserviced groups,[28] e.g., elderly, mentally defective, hearing-impaired, drug-dependent, physically handicapped, poor,[30] chronically ill, some ethnic groups, some who live in rural areas, people in prisons, retarded children, the unemployed, and patients with AIDS.[10] There are problems of accessibility for patients and availability of practitioners at the place and time when they are needed. Practitioners (especially physicians) prefer to remain in large cities.

Costs of new technology

The explosion of new technology, the need for complex and expensive devices and facilities, and the constant need to update and replace equipment and modernize hospitals[6] tend to increase costs.[25] Patients are becoming more sophisticated and expect a higher standard of care. However, health care needs more emphasis on humanity and less on high technology.

Cost of malpractice insurance

The high cost of malpractice insurance is considered to be a factor which forces doctors to practice defensively e.g., order extra tests which further increase costs.[18,31,32] There is an obvious need to limit malpractice awards, while providing a fair settlement to the victim. At the same time one might suggest an increase in the length of time that the guilty practitioner is suspended from practice by the professional licensing body. This is not entirely an example of double jeopardy as the cash payment is usually made by the practitioner's insurance company.

Inadequate inter-professional cooperation

There is a clear need for improved inter-professional cooperation.[28] There are no completely independent health professions.[33] Inter-professional jealousy, distrust, and financial competition still exist and are likely to increase as competition for the limited health dollar becomes more intense.[16] The resulting inefficiency in the system further increases costs.

Commercialization of the professions

Recent actions of governments in the United States, Canada, and the United Kingdom have had the effect of downgrading the professions and placing professionals in the category of "merchants." Note the encouragement of advertising by professionals. Presumably governments think that a a market-driven economy will help control costs of health care.[18] There is no evidence to support this concept but the risk of a decline in quality is high. The marketing of health care for profit erodes the status of the practitioner and increases the frequency of malpractice claims. Practitioners who advertise will be regarded simply as the seller of a product. Caveat emptor.

Insufficient or ineffective quality control

There is a need for quality control, and for effective ways to detect and deal with those who practice in a substandard way.[20] The era of accountability is here.[11] Professions have done a poor job of policing their own members. A few practitioners whose practice is oriented to making money or whose competence is marginal have been allowed to continue to exploit patients at the very time when they are vulnerable.[19]

Emphasis on cure instead of care

Too much emphasis has been placed on cure rather than on care. Education and grant support focus on cure. More and better chronic care facilities are needed. For-profit companies could play a role here.

Insufficient attention to prevention

Health planning and health education have traditionally placed too little emphasis on prevention.[9,34] In terms of cost and quality of life, prevention is better than detection or treatment. The major causes of death (heart disease, cancer, strokes, accidents, and diseases of the liver and lungs) all are largely determined by excess cholesterol, lack of exercise, smoking, carelessness, and alcohol abuse.[32] It is obvious that our "self-inflicted" wounds cause a significant portion of our illnesses. Up to now the major improvements in health have been due to improved sanitation, safe drinking water, limitation of family size, better nutrition and improvements in our environment.[21] Future improvements in health are likely to depend on similar life-style factors.[9,21] It is difficult to convince all those involved that patients have some responsibility for their own health care (life-style changes) and that health professionals must allocate more of their time and resources to preventing illness. The present attack on environmental pollution is a step in the right direction. Someone has suggested that we need a system like that which is said to have existed at one time in China. Under that system each person paid the doctor as long as the person remained well but payments to the doctor ceased when the person became ill.

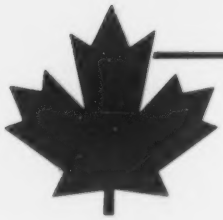
Irrational ad hoc planning

Health services need rationalization, better allocation of resources to avoid duplicating expensive facilities, and more efficient administration.[9,13] Flexibility is necessary to deal with the inevitable changes which are occurring as a result of the factors described above.[16,27] The public must decide on the balance between accessibility, quality and costs of health care. Different groups rank these key factors in different orders of importance.

Health care problems identified in Canada

1. Practitioners want to charge more than the health plan permits but are not allowed to do so.[34] Practitioners in Ontario can charge only for the work they perform themselves and not for the work of technicians.[6]

2. Practitioners must periodically



negotiate overall fees with the provincial government.[6,34]

3. Strikes by physicians were unsuccessful and were recognized as self-serving. The problem was not professional autonomy as some physicians claimed, but more money as other physicians pointed out.[6] Physicians do worry about their autonomy and feel threatened by the need to restrict their fees and reduce their numbers.

4. When National Health Care was introduced, some physicians left Canada (less than 1 percent) but over 500 foreign physicians enter Canada each year and some Canadian physicians who did leave have since returned to Canada. The supply of physicians continues to increase in Canada at between 1.5 and 2 percent per year.[16] The rate of increase in the number of physicians in Ontario is nearly 5 times the rate of population increase. According to the Registered Nurses Association of Ontario, we would need 30 percent fewer physicians in Ontario if nurses were allowed to function as midwives and nurse practitioners. They already function in these roles in some outpost nursing stations in Canada's north.

5. Pressure is on practitioners to see more patients in order to increase their income.[9] Half of the current increase in physicians' income is the result of seeing more patients. (Physicians under this kind of pressure have little time or incentive to offer life-style counseling.)

6. When most costs are paid by a third party, the patient becomes less concerned about the costs of health care. It would be illuminating to the public to send each patient a year-end statement showing the total costs of that person's health care. Such a procedure might also influence practitioner billing practices.

7. There is a tendency to keep patients too long in acute care facilities because of insufficient chronic care facilities. Hospitals account for 40 percent of health care spending. A recent estimate by the Registered Nurses Association of Ontario indicates that 20% of the patients in acute care beds in Ontario hospitals could be cared for adequately and less expensively in chronic care or home care facilities if these were available. In Ontario in 1982, nursing home residents paid $15.68 a day and the government paid $42.35 a day for their care. Home care costs for a patient are estimated to be about half that of nursing home costs. In Ontario, Comprehensive Health Organizations are being set up. These are modeled on the HMO's in the United States and are expected to reduce hospital use by 10 percent. The number of "store-front" medical, dental and optometrical offices is increasing. Hospitals are closing some beds, and this makes it even more difficult for a physician to get a bed allotment.[16,31]

Many practitioners and some of the public in the United States prefer a "pluralistic" system.

8. Access to care is not as good as it might be in some remote areas (but air ambulance service is readily available and widely used).

9. Optometrists must be able to justify the standard of care provided and the fees charged. Adequate records must be kept. Optometrists' accountability is presently to their own self-governing body. If a member of the public has a complaint, the optometrist's records can be reviewed by a peer review committee and the member can be disciplined.

10. Optometrists are not usually integrated into hospitals and other health care facilities. This integration is less common in Canada than in the United States or in the United Kingdom.[33]

11. There is a need for more recognition of and adequate payment for diagnostic services by optometrists and less reliance on dispensing fees.[33] Ophthalmologists are paid an additional fee for each of certain procedures but an optometrist who performs the same procedure is not reimbursed. This peculiar anomaly seems to be a legacy from former times when only ophthalmologists were paid for eye examinations.

Health care problems identified in the United States

1. From 15 to 30 percent of the population has no (or inadequate) health insurance[1,3,7,16] and this number is increasing.[30] This pool of people provides a potential focus for disease, especially if prenatal care, immunization and nutrition are substandard. Deferring prenatal care and care for such conditions as hypertension and diabetes eventually result in greater costs.[1] This cost escalation overlooks the humanitarian factors of illness, disability, and a shortened life. County hospitals (for those who can not pay) are said to provide a lower quality of care—a two-tier system.[30] Low income persons receive substantially less care.[30] About 46 percent of low income citizens in the United States are covered by Medicaid.[30] The Medicare and Medicaid legislation were passed in 1966.[11] Medicare pays primarily for acute care. Medicare fees provide about 20 percent of the average physician's income.

Unfortunately Medicare and Medicaid exacerbated the inflation of health costs because to a certain extent they locked in the fee-for-service payment system.[1] Before becoming eligible for Medicaid coverage residents of a nursing home must exhaust their own funds;[35,36] there is a means test. The cost of long term care in the United States is paid as follows: 43% by Medicaid, 2% by Medicare, less than 2% by group and individual health insurance,[36] and the rest by government assistance.

2. A few practitioners appear to value freedom of choice more highly than equality of outcome.[23,37] In effect this means that the rich and the poor have an equal right to sleep under a bridge. Competitive health care markets have no interest in the poor and the uninsured.[7] Defenders of an entrepreneurial system point out that the Constitution

does not guarantee equal health care to all. In the United States, only prisoners and military personnel are legally entitled to health care at government expense.

3. The cost of malpractice insurance and the frequency of lawsuits are higher in the United States. Fear of malpractice suits forces doctors to order excessive laboratory and other tests. Providing sensitive, empathetic care is time-intensive and not easy to prove if a doctor is sued for malpractice, however it does decrease the likelihood of being sued.

4. The shift to a for-profit system allowed the quality of care for many to be eroded; costs did not decrease and problems of access and equity were aggravated.[6,7] The once popular shift to for-profit companies is now slowing down. The four big for-profit health companies are selling off some of their facilities.[25] Their bed occupancy rate is less than 60 percent.[12] (Bed occupancy rate in Ontario hospitals in 1985 was 87 percent.) About 700 hospitals will be closed in the United States within six years.[10] The traditional emphasis has been on acute care. As in Canada there is a great shortage of chronic care facilities. At least three-quarters of nursing homes are proprietary in the United States,[31] and in Ontario about 70 percent are proprietary, but in other parts of Canada most are government supported. Cost of one year's care in a nursing home is at least $25,000[35] and is roughly equal in the United States and Canada.

5. Potential for excess surgery and hospitalization. Frequency of surgery and hospital admissions are much lower in HMO facilities[12] (where doctors are on salary)—a fact which implies that surgery and hospital admissions are excessively high in fee-for-service type practices. Patients are enrolled as members in an HMO and pay a fixed annual fee. Hospital use by these patients is reduced by about 40 percent and health care costs are nearly 35 percent less. In a HMO the patient's choice of doctor is restricted.[37] Preferred provider organizations (PPOs) are now becoming popular in the United States.[10] The PPO retains the fee-for-service concept but fees are usually lower than customary charges and the patient's choice of providers is limited.[32] Prepaid group practices can reduce costs of health care by 10 to 40 percent.[1]

Advantages in Canada

Health care is universal, comprehensive and portable. One hundred percent of Canadian residents are entitled to the insured health services provided by the plan under specified terms and conditions. All provinces, except one, include optometrists' services in their plans.

This new Act stipulated that 100 percent of Canadians are entitled to insured health services.

Although the extent of coverage may vary slightly, this coverage provides a ready source of patients and income to the optometrists. The home province or territory pays, at host province rates, for services received out-of-province and out-of-country.

Advantages in the United States

Practitioners feel less constrained by government and by the prospect of peer review of the quality of their work and by the prospect of control of the fees charged. Many practitioners and some of the public in the United States prefer a "pluralistic" system. Some practitioners achieve a higher income.

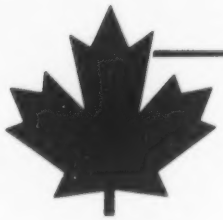
For optometrists there are stimulating opportunities to gain experience for a year or two in VA hospitals or in military hospitals. Optometrists who have had this experience have exerted a profound change on optometry in the United States. Optometrists also serve in the Public Health Service and in the Civil Service.

Canada's National Health Plan

In 1968 Canada committed itself to implementation of the Medical Care Act of 1966 and to the provision of high quality care to no fewer than 95 percent of its almost 26 million citizens, rich or poor, sick or well, rural or urban.[4,21,39] The Federal Hospital Insurance Act was passed in 1957.[4] In 1984 the Canada Health Act replaced the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. This new Act stipulated that 100 percent of Canadians are entitled to insured health services. Most Canadians believe that a society reveals its values by the human services it provides. Just as every child is entitled to an education, it is felt every person is entitled to the best available health care. Some organizations tend to fight against a public health care plan.[40] At different times and in different ways the Medical Associations,[6] the Insurance Industry and parts of the Pharmaceutical Industry have resisted development of a National Health Plan. In Canada the Canada Health Plan is tax funded, but some provinces charge premiums. In a typical Canadian hospital there is no way you can tell who is rich and who is poor.[6]

Canada's health status looks to be as good as that of United States.[3] Tables of morbidity, disability and mortality indicate much similarity. It has always been difficult to measure the quality of health care but some data tend to show that health care in Canada is of good quality. The rate of infant mortality and neonatal mortality (Tables 6,7) is lower in Canada than in the United States. Life expectancy at birth is slightly longer for females and males in Canada than in the United States.

Most Canadians are satisfied with health care services as currently provided; over 80 percent express satisfaction with the system.[3,21] The public in the United States and in the United Kingdom have expressed a relatively



low level of satisfaction with the provision of health care in their own countries.[6,41]

Conclusion

It is clear that the United States and Canada have chosen different ways to control the costs of health care. Now both systems must perform more selective allocation of resources and more rationing of care. Neither system solves all the problems. No country has achieved a system which relates management of health care to outcomes.[11] Neither Canada nor the United States has been able to reach the low infant mortality rates achieved by Japan or match their life expectancy at birth (75.2 years for males, 80.9 years for females).[42] Japan spends 6.7% of their GNP on health care. A high proportion of GNP spent on health care does not necessarily result in a healthier population. Factors such as lifestyle and occupational and environmental hazards have to be considered.

Most of the disadvantages in the Canadian health care system are from the viewpoint of the practitioner. Although there are more controls on the practitioner they also have the benefit of a guaranteed income. They may not be paid what they feel they are worth but they do get paid. The main flaw in this system is that with removal of all barriers to access there is no control on utilization of the system. This results in overusage of the system by consumers who view health care as "free" and by practitioners who increase their income by increasing their patient load.

Under the United States health care system the main disadvantages are for the consumer of health care while all the advantages are for the practitioner. Whether a universal health insurance system would work in the United States as well as it has in Canada is difficult to say. It is not possible to transplant one health care model to another country due to differences in traditions, experience and philosophy. It should be possible for each country to learn from others and to incorporate modified components of another health care system in order to benefit its citizens.

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